STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445420	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SISKIN HOSPITAL SUBACUTE REHAB	ONE SISKIN PLAZA CHATTANOOGA, TN 37403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to perform all tests on the automatic sprinkler system. The findings include: Record review and interview with facilities director on September 22, 2014 at 11:20 a.m. revealed no 5 year sprinkler gauge replacement or calibration has been conducted. No documentation could identify when the last sprinkler gauges were replaced or calibrated. NFPA 25 2-3.2 This finding was verified by the facilities director and acknowledged by administration during the exit conference on September 22, 2014.	K 062	The five-year fire sprinkler gauges were replaced on September 24, 2014. The replacement was documented in the Vendor Inspection Manual. Measures were taken to ensure no future incidents related to calibration/replacement of the gauges. This procedure has been added to the facility's updated electronic Preventative Maintenance Program to ensure the five-year gauge calibration/replacement is completed on time in the future. This program is monitored on a monthly basis through the facility's Quality Assessment/Performance Improvement (QAPI) program. Compliance is reported through the Environment of Care Committee.	10/28/14
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to maintain fire rated wall assemblies.	K 130	Diana L. Miller, NHA Tod Cain, V.P. Administration Jim Allyn, Facilities Director	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Diana L. Miller NHA 10/9/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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SISKIN HOSPITAL SUBACUTE REHAB	ONE SISKIN PLAZA CHATTANOOGA, TN 37403

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K 130	Continued From page 1 The findings include: Observation on September 22, 2014 at 12:20 p.m. revealed above ceiling for the fire rated walls at the exit stairwell across from room 332 and above ceiling of the fire doors by the dining room, has unsealed penetrations. This finding was verified by the facilities director and acknowledged by administration during the exit conference on September 22, 2014. NFPA 101 8.2.3.2.4 Penetrations and Miscellaneous Openings in Fire Barriers. 8.2.3.2.4.1* Openings in fire barriers for air-handling ductwork or air movement shall be protected in accordance with 9.2.1. 8.2.3.2.4.2* Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable	K 130	A staff member has successfully completed 3M training in proper application of fire protection products for through penetrations and will repair the cited firewall penetrations by October 28, 2014. To ensure there are no additional firewall penetrations within the facility, a full inspection of the facility will be completed by October 28, 2014. To ensure that firewall penetrations are properly addressed in the future, this individual will assist in ensuring compliance with existing policy that requires a vendor or staff member to obtain a work permit before beginning above-ceiling projects. The policy is being revised to more fully clarify the process for inspection following work completion. **CONTINUED**	10/28/14

Diana J Mc NHA 10/9/14

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K 130	Continued From page 2 of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) * Insulation and coverings for pipes and ducts shall not pass through the fire barrier unless one of the following conditions is met: a. The material shall be capable of maintaining the fire resistance of the fire barrier. b. The material shall be protected by an approved device that is designed for the specific purpose. 4) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the fire barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 130	Compliance with this regulation is monitored through the Quality Assessment/Performance Improvement (QAPI) program and is reported through the Environment of Care committee, with appropriate action being taken by that committee. Diana L. Miller, NHA Tod Cain, V.P.; Administration Jim Allyn, Facilities Director	

Diana L Miller, NHA 10/9/14